		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025239

Facility Name: ROLLING HILLS MANOR

Address: 3515 16TH STREET (Number) ZION, ILLINOIS (City) 60099 (Zip Code)

County: LAKE

Telephone Number: (847)746-8382 **Fax #** (847)746-3545

IDPA ID Number: 36-2770969

Date of Initial License for Current Owners: 8/30/1980

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code 501C3		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: JAMES S. STEFO **Telephone Number:** (547)427-0701

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 11/01/2002 to 10/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) 02/24/2004 (Date)
(Type or Print Name) ANNE L. SCOTT
(Title) VICE PRESIDENT

Paid Preparer
(Signed) 02/24/2004 (Date)
(Print Name and Title) JAMES S. STEFO
(Firm Name & Address) JAMES S. STEFO AND CO. 700 NICHOLAS BLVD. ELK GROVE, IL. 60007
(Telephone) (847)427-0701 Fax # (847)427-0621

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 1/25/2002

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	130	Skilled (SNF)	130	47,450	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	130	TOTALS	130	47,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,463	10,424	5,326	28,213	8
9	SNF/PED					9
10	ICF	8,990	8,199		17,189	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	21,453	18,623	5,326	45,402	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.68%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/1979

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/1979 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 130 and days of care provided 5,326

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 10/31/2003 Fiscal Year: 10/31/2003

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 **Report Period Beginning:** 11/01/2002 **Ending:** 10/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	334,243	33,543	40,333	408,119		408,119		408,119			1
2	Food Purchase		198,172		198,172	(23,647)	174,525	(1,416)	173,109			2
3	Housekeeping	219,000	15,392	3,465	237,857		237,857		237,857			3
4	Laundry	107,298	12,075	2,984	122,357		122,357	(9,095)	113,262			4
5	Heat and Other Utilities			134,171	134,171		134,171		134,171			5
6	Maintenance	89,478	34,574	74,080	198,132		198,132	(15,277)	182,855			6
7	Other (specify):* Rolling Hills Place			594,125	594,125		594,125	(594,125)				7
8	**TOTAL General Services**	750,019	293,756	849,158	1,892,933	(23,647)	1,869,286	(619,913)	1,249,373			8
	B. Health Care and Programs											
9	Medical Director			2,410	2,410		2,410		2,410			9
10	Nursing and Medical Records	2,466,519	157,319	215,396	2,839,234	(145,113)	2,694,121		2,694,121			10
10a	Therapy			318,866	318,866		318,866		318,866			10a
11	Activities	90,528	8,826	4,332	103,686		103,686		103,686			11
12	Social Services	51,447		1,371	52,818		52,818		52,818			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Rolling Hills Place			112,209	112,209		112,209	(112,209)				15
16	**TOTAL Health Care and Programs**	2,608,494	166,145	654,584	3,429,223	(145,113)	3,284,110	(112,209)	3,171,901			16
	C. General Administration											
17	Administrative	83,660		85,592	169,252		169,252	(85,592)	83,660			17
18	Directors Fees			23,035	23,035		23,035		23,035			18
19	Professional Services			115,480	115,480		115,480		115,480			19
20	Dues, Fees, Subscriptions & Promotions			43,430	43,430		43,430	(20,342)	23,088			20
21	Clerical & General Office Expenses	279,453	53,264	156,587	489,304		489,304	(33,809)	455,495			21
22	Employee Benefits & Payroll Taxes			606,800	606,800	23,647	630,447		630,447			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,448	10,448		10,448		10,448			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			46,360	46,360		46,360		46,360			26
27	Other (specify):* Rolling Hills Place			353,963	353,963		353,963	(353,963)				27
28	**TOTAL General Administration**	363,113	53,264	1,441,695	1,858,072	23,647	1,881,719	(493,706)	1,388,013			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,721,626	513,165	2,945,437	7,180,228	(145,113)	7,035,115	(1,225,828)	5,809,287			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number ROLLING HILLS MANOR #0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			205,970	205,970		205,970	6,847	212,817			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			74,940	74,940		74,940	(32,472)	42,468			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* Rolling Hills Pl			358,664	358,664		358,664	(358,664)				36
37	**TOTAL Ownership**			639,574	639,574		639,574	(384,289)	255,285			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			3,351	3,351		3,351		3,351			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			71,175	71,175		71,175		71,175			42
43	Other (specify):* PRSCR DRUGS					145,113	145,113	(42,468)	102,645			43
44	**TOTAL Special Cost Centers**			74,526	74,526	145,113	219,639	(42,468)	177,171			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,721,626	513,165	3,659,537	7,894,328		7,894,328	(1,652,585)	6,241,743			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients	(15,277)	6		7
8	Laundry for Non-Patients	(9,095)	4		8
9	Non-Straightline Depreciation	6,847	30		9
10	Interest and Other Investment Income	(32,472)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,416)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(85,592)	17		24
25	Fund Raising, Advertising and Promotional	(20,342)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule BOND COSTS	(42,468)	43		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (199,815)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	1,452,770		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 1,452,770		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 1,652,585		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs	X		145,113	10	43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$ 145,113		47

ROLLING HILLS MANOR

ID# 0025239

Report Period Beginning: 11/01/2002

Ending: 10/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary B

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 **Report Period Beginning:** 11/01/2002 **Ending:** 10/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	6,847	0	0	0	0	0	0	0	0	0	0	6,847	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(32,472)	0	0	0	0	0	0	0	0	0	0	(32,472)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	(358,664)	0	0	0	0	0	0	0	0	0	(358,664)	36
37	**TOTAL Ownership**	(25,625)	(358,664)	0	0	0	0	0	0	0	0	0	(384,289)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(157,347)	(1,452,770)	0	0	0	0	0	0	0	0	0	(1,610,117)	45

STATE OF ILLINOIS — Summary A

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,416)	0	0	0	0	0	0	0	0	0	0	(1,416)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(9,095)	0	0	0	0	0	0	0	0	0	0	(9,095)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(15,277)	0	0	0	0	0	0	0	0	0	0	(15,277)	6
7	Other (specify):*	0	(594,125)	0	0	0	0	0	0	0	0	0	(594,125)	7
8	**TOTAL General Services**	(25,788)	(594,125)	0	0	0	0	0	0	0	0	0	(619,913)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	(112,209)	0	0	0	0	0	0	0	0	0	(112,209)	15
16	**TOTAL Health Care and Programs**	0	(112,209)	0	0	0	0	0	0	0	0	0	(112,209)	16
	C. General Administration													
17	Administrative	(85,592)	0	0	0	0	0	0	0	0	0	0	(85,592)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(20,342)	0	0	0	0	0	0	0	0	0	0	(20,342)	20
21	Clerical & General Office Expenses	0	(33,809)	0	0	0	0	0	0	0	0	0	(33,809)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	(353,963)	0	0	0	0	0	0	0	0	0	(353,963)	27
28	**TOTAL General Administration**	(105,934)	(387,772)	0	0	0	0	0	0	0	0	0	(493,706)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(131,722)	(1,094,106)	0	0	0	0	0	0	0	0	0	(1,225,828)	29

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SLOVAK AMERICAN CHARIATBLE ASSOCIATION	100	N/A	N/A	N/A	N/A	N/A
N/A	N/A	N/A	N/A	ROLLING HILLS PLACE	ZION. ILLINOIS	ASISTED LIVING FACILITY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	ADMINISTRATIVE EXPENSES	$ 33,809	SLOVAK AMERICAN CHARITABLE ASSOCIATION	100.00%	$	$ (33,809)	1
2	V	7	GENERAL SERVICES	594,125	ROLLING HILLS PLACE	N/A		(594,125)	2
3	V	15	HEALTHCARE & PROGRAMS	112,209	ROLLING HILLS PLACE	N/A		(112,209)	3
4	V	27	GENERAL ADMINISTRATION	353,963	ROLLING HILLS PLACE	N/A		(353,963)	4
5	V	36	CAPITAL ESPENSES	358,664	ROLLING HILLS PLACE	N/A		(358,664)	5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 1,452,770			$	$ * (1,452,770)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	GEORGE JANAC	DIRECTOR	PRESIDENT	NONE	NONE	1/2 HR.	2.00	DIR. FEE	$ 1,225	18-3	1
2	GEORGE JANAC	DIRECTOR	BUSINESS MAN.	NONE	NONE	8 HRS.	20.00	DIR. FEE	11,330	18-3	2
3	ANNE SCOTT	DIRECTOR	VICE PRES.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,755	18-3	3
4	JUDITH JANAC	DIRECTOR	SECRETARY	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,475	18-3	4
5	ANN MEDO	DIRECTOR	TREASURER	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,475	18-3	5
6	JAMES STEFO, SR.	DIRECTOR	FIN'L SECR'Y	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,350	18-3	6
7	JANET PILCH	DIRECTOR	MGMT COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,475	18-3	7
8	ELEANOR PETRAS	DIRECTOR	MGMT COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,475	18-3	8
9	NAN STEFO	DIRECTOR	MGMT COMM.	NONE	NONE	1/2 HR.	2.00	DIR. FEE	1,475	18-3	9
10											10
11											11
12											12
13								TOTAL	$ 23,035		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 0/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2		N/A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	IDFA REVENUE BONDS			REFINANCING OF SERIES			$	$			$	1
2	SERIES 2000		X	1991 REVENUE BONDS	$11,000.00	6/29/2000	2,600,000	2,506,244	6/29/2030	VAR.	32,472	2
3												3
4	BOND COSTS										42,468	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$11,000.00		$ 2,600,000	$ 2,506,244			$ 74,940	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 2,600,000	$ 2,506,244			$ 74,940	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ NONE Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2002 report.	$	NONE	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	NONE	2
3. Under or (over) accrual (line 2 minus line 1).	$	NONE	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	NONE	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	NONE	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	NONE	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	NONE	8
	1999	NONE	9
	2000	NONE	10
	2001	NONE	11
	2002	NONE	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1200.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME ROLLING HILLS MANOR COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0025239

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 51,632 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

ROLLING HILLS PLACE
ASSISTED LIVING FACILITY
48000 SQUARE FEET
68 BEDS/60 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A 2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A 4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	3 ACRES	1970	$ 100,763	1
2					2
3	TOTALS	3 ACRES		$ 100,763	3

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	130		1979	1970	$ 927,078	$ 10,896	40	$ 17,743	$ 6,847	$ 783,645	4
5	PREMIUM		1979	1979	712,648	20,362	35	20,362		488,669	5
6	RENOVATIONS		1992	1992	1,234,270	30,857	40	30,857		354,855	6
7	RENOVATIONS		1992	1992	232,299		10			232,299	7
8	RENOVATIONS		1998	1998	695,702	17,393	40	17,393		87,732	8
	Improvement Type**										
9	AIRLOCK			1982	3,886					3,886	9
10	ROOF			1983	41,724	1,047		1,047		41,724	10
11	PLUMBING FIXTURES			1983	3,845	97		97		3,846	11
12	ROOF AND HEATER			1984	118,647	5,932		5,932		115,777	12
13	AIR CONDITIONING UNITS			1984	37,141					37,141	13
14	HEATING UNITS			1985	1,061					1,061	14
15	RAMP			1985	38,992	2,004		2,004		36,114	15
16	MIXING VALVE			1985	325	16		16		311	16
17	FENCE			1986	1,257	63		63		1,105	17
18	RAMP			1986	5,400	270		270		4,720	18
19	ROOF			1986	33,997	1,697		1,697		29,747	19
20	HEATING UNITS			1988	6,344					6,344	20
21	FLOOD DEVICE			1989	7,418					7,418	21
22	ELECTRIC PANEL			1989	6,354					6,354	22
23	HALLWAY LIGHTING			1990	8,091					8,091	23
24	ALARM SYSTEM			1991	6,775					6,775	24
25	PELLA WINDOWS			1992	4,367					4,367	25
26	PELLA WINDOWS			1992	3,661					3,661	26
27	ROOF			1993	24,500	1,225		1,225		24,500	27
28	PELLA WINDOWS			1993	14,624	731		731		7,676	28
29	ROOF			1994	24,500	1,225		1,225		22,050	29
30	HEATERS			1994	6,987	357		357		6,246	30
31	WATER LINE			1994	6,820	341		341		3,240	31
32	PARKING LOT SURFACE			1994	4,346	217		217		3,584	32
33	ROOF			1995	24,800	2,480		2,480		21,080	33
34	HOT WATER SYSTEM			1995	18,175	1,818		1,818		15,353	34
35	DOOR LOCKS			1995	12,473	1,190		1,190		10,655	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	CALL LIGHTING SYSTEM	1996	$ 14,321	$ 1,432	10	$ 1,432	$	$ 10,740	37
38	RETAINING WALL	1996	38,975	1,949	20	1,949		14,617	38
39	OXYGEN ENVIRONMENT	1996	3,892	226	10	226		2,755	39
40	EMERGENCY GENERATOR	1996	10,089	673	15	673		5,047	40
41	CANOPIES	1997	2,490	249	10	249		1,619	41
42	KITHCEN TILING	1997	3,507	350	10	350		2,275	42
43	AIR CONDITIONING UNIT	1997	5,970	597	10	597		3,881	43
44	ROOF	1998	5,500	550	10	550		3,025	44
45	SIGN	1999	2,768	69	40	69		345	45
46	SIGN	1999	4,668	117	40	117		585	46
47	PELLA WINDOWS	1999	7,855	393	20	393		2,000	47
48	CARPETING AND WALLPAPER	2000	9,279	760	10	760		2,660	48
49	SMOKE SENSORS	2000	12,985	814	10	814		2,957	49
50	ROOF	2000	12,585	630	20	630		2,205	50
51	SEWER EXTENSION	2000	11,480	574	20	574		2,009	51
52	SHRUBBERY	2001	2,211	147	15	147		368	52
53	PAINT AND WALLPAPER	2001	1,510	151	10	151		378	53
54	VINYL FLOORING	2001	9,602	903	10	903		2,343	54
55	CARPETING	2001	17,556	1,756	10	1,756		4,390	55
56	HAND RAILS	2001	11,425	571	20	571		1,428	56
57	PRESSURE VALVE	2001	4,636	232	20	232		580	57
58	EXHAUST FANS	2001	3,994	200	20	200		500	58
59	CARPETING AND TILE	2002	80,772	8,077	10	8,077		12,116	59
60	HAND RAILS	2002	28,365	1,418	40	1,418		2,127	60
61	CLASSROOM FLOORS AND WALLS	2002	2,970	148	40	148		222	61
62	WOOD COLUMNS	2002	7,050	353	40	353		530	62
63	FLOOR OUTLETS	2002	4,606	230	40	230		345	63
64	DOORS	2002	7,360	368	40	368		552	64
65	VINYL FLOORING	2003	29,600	1,480		1,480		1,480	65
66	DOORS	2003	6,835	171		171		171	66
67	SIDEWALKS	2003	4,352	109		109		109	67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,637,715	$ 125,915		$ 132,762	$ 6,847	$ 2,464,385	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 573,229	$ 68,191	$ 68,191	$	VARIOUS	$ 258,254	71
72	Current Year Purchases	92,086	7,409	7,409		VARIOUS	7,049	72
73	Fully Depreciated Assets	940805	4,455	4,455		VARIOUS	940,805	73
74								74
75	TOTALS	$ 1,606,120	$ 80,055	$ 80,055	$		$ 1,206,108	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	BUSINESS	1995 FORD ELDORADO	1995	$ 40,018	$	$	$		$ 40,018	76
77										77
78										78
79										79
80	TOTALS			$ 40,018	$	$	$		$ 40,018	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,384,616	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 205,970	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,817	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,847	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 3,710,511	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$ NONE	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL		N/A		$ N/A **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$ N/A	$ N/A	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$ NONE			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	NONE

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10A	hrs	$		$ 136,218	$		$ 136,218	1
2	Licensed Speech and Language Development Therapist	10A	hrs			16,032			16,032	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10A	hrs			155,574			155,574	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$ 307,824	$		$ 307,824	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 10/31/2003 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 43,565	$ 393,452	1
2	Cash-Patient Deposits	12,274	12,274	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 120,000)	1,462,408	1,469,034	3
4	Supply Inventory (priced at COST)	21,005	28,331	4
5	Short-Term Investments		21,155	5
6	Prepaid Insurance	11,155	11,155	6
7	Other Prepaid Expenses	12,671	35,564	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,563,078	$ 1,970,965	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments		1,020,827	12
13	Land	100,763	236,453	13
14	Buildings, at Historical Cost	4,637,715	10,821,643	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,646,138	2,304,323	16
17	Accumulated Depreciation (book methods)	(3,710,511)	(4,203,359)	17
18	Deferred Charges	184,653	461,320	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,858,758	$ 10,641,207	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,421,836	$ 12,612,172	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 129,820	$ 286,136	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	12,274	12,274	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	113,532	122,303	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,173	6,854	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	RESIDENT AND OTHER CREDITS	223,437	344,437	36
37	DUE TP SACA	76,771		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 558,007	$ 772,004	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	2,506,244	7,905,000	41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,506,244	$ 7,905,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,064,251	$ 8,677,004	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,357,585	$ 3,935,168	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,421,836	$ 12,612,172	48

***(See instructions.)**

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,750,381	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,750,381	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	184,787	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 184,787	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,935,168	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,789,340	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,789,340	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,084,410	6
7	Oxygen	31,229	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,115,639	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	15,277	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	9,095	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 24,372	23
	D. Non-Operating Revenue		
24	Contributions	33,418	24
25	Interest and Other Investment Income***	116,346	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 149,764	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,079,115	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,892,933	31
32	Health Care	3,429,223	32
33	General Administration	1,858,072	33
	B. Capital Expense		
34	Ownership	639,574	34
	C. Ancillary Expense		
35	Special Cost Centers	3,351	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,894,328	40
41	**Income before Income Taxes (line 30 minus line 40)****	184,787	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 184,787	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,928	2,064	$ 62,506	$ 30.28	1
2	Assistant Director of Nursing	1,824	2,076	55,226	26.60	2
3	Registered Nurses	17,205	17,991	457,469	25.43	3
4	Licensed Practical Nurses	18,190	20,454	419,712	20.52	4
5	Nurse Aides & Orderlies	101,003	110,984	1,327,554	11.96	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,848	6,625	86,028	12.99	8
9	Activity Director	1,675	1,804	24,174	13.40	9
10	Activity Assistants	6,306	6,579	66,354	10.09	10
11	Social Service Workers	2,390	2,550	51,447	20.18	11
12	Dietician	256	256	6,663	26.03	12
13	Food Service Supervisor	632	640	12,616	19.71	13
14	Head Cook	6,741	7,306	101,337	13.87	14
15	Cook Helpers/Assistants	24,615	25,825	213,627	8.27	15
16	Dishwashers					16
17	Maintenance Workers	7,007	7,768	89,478	11.52	17
18	Housekeepers	24,825	26,476	219,000	8.27	18
19	Laundry	10,821	11,689	107,298	9.18	19
20	Administrator	1,952	2,179	83,660	38.39	20
21	Assistant Administrator					21
22	Other Administrative	15,959	16,403	227,740	13.88	22
23	Office Manager	2,054	2,314	51,713	22.35	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	1,945	2,273	58,024	25.53	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	253,176	274,256	$ 3,721,626 *	$ 13.57	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	369	$ 27,664	1-3	35
36	Medical Director	32	2,410	9-3	36
37	Medical Records Consultant	35	1,560	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	58	5,731	10A-3	40
41	Occupational Therapy Consultant	46	4,561	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		750	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	540	$ 42,676		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	10	$ 980	10-3	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	10	$ 980		53

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUE HARRIS	ADMINISTRATOR	NONE	$ 83,660
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 83,660

B. Administrative - Other

Description	Amount
BAD DEBT EXPENSE	$ 85,592
TOTAL (agree to Schedule V, line 17, col. 3)	$ 85,592
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ALTSCHULER, MELVOIN & GLASSER	AUDITING FEES	$ 23,455
JAMES S. STEFO & CO.	ACCOUNTING FEES	51,000
REVERE HEALTH CARE, LTD.	BILLING SYSTEM WORK	14,002
BEST AND FRIEDRICH	LEGAL FEES	7,641
DUANE MORRIS LLP	LEGAL FEES	12,349
BANK ONE	BOND FEES	4,200
ADP	PAYROLL PROCESSING	2,833
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 115,480

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 72,530
Unemployment Compensation Insurance	24,380
FICA Taxes	284,984
Employee Health Insurance	215,421
Employee Meals	23,647
Illinois Municipal Retirement Fund (IMRF)*	
RETIREMENT FUNDING	17,047
BENEFIT ACCRUAL RECOVERY	(7,562)
TOTAL (agree to Schedule V, line 22, col.8)	$ 630,447

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,105
Health Care Worker Background Check	
(Indicate # of checks performed)	
ADVERTISING	20,342
INSPECTIONS AND FEES	5,151
LIFE SERVICES NETWORK	11,591
MEMBERSHIPS	1,629
LITERATURE AND APPLICATIONS	3,612
Less: Public Relations Expense	( )
Non-allowable advertising	(20,342)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 23,088

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
AUTO EXPENSE	727
TRAVE REIMBURSEMENT	4,193
Seminar Expense	5,528
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,448

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ NONE		$	$	$	$	$	$	$	$	$

Facility Name & ID Number ROLLING HILLS MANOR # 0025239 Report Period Beginning: 11/01/2002 Ending: 10/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **11591**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **NO** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **5-10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **28,628** Line **10-3**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **71,175**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **NO** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **23,647** Has any meal income been offset against
related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **NO** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **ALTSCHULER, MELVOIN, AND GLASSER** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **NO** If no, please explain. **IN TYPING, AWAITING DELIVERY**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

10/31/2003 RECLASSIFICATIONS

SCHEDULE V COLUMN 5, LINES 2 AND 22

$23647 OF EMPLOYEE MEALS HAVE BEEN DEDUCTED FROM LINE 2 (FOOD COSTS) AND HAVE BEEN ADDED TO LINE 22 (EMPLOYEE BENEFITS).

SCHEDULE V COLUMN 5, LINES 10 AND 43.

$145113 OF PRESCRIPTION DRUG COSTS HAVE BEEN DEDUCTED FROM LINE 10 (NURSING COSTS) AND HAVE BEEN ADDED TO LINE 43 (SPECIAL COST CENTERS - OTHER).